DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OTC 6/16/12

PRINTED: 05/03/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445277	A. BUILDING _____ B. WING _____	C 05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MCMINN MEMORIAL NURSING HOME & REHAB CENTER	886 HWY 411 NORTH ETOWAH, TN 37331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility investigation documentation, observation, and interview, the facility failed to provide adequate supervision and/or assistance to prevent a fall with injury for one resident (#4) of five sampled residents. The findings included: Resident #4 was admitted to the facility on August 11, 2011, with diagnoses including Failure to Thrive and Dementia with Behavioral Disturbance. Medical record review of a Fall Risk Assessment dated November 23, 2011, revealed a score of 20 and a score of 20 or greater represented high risk. Medical record review of a Minimum Data Set dated February 20, 2012, revealed the resident was severely impaired with decision-making skills, non-ambulatory, and required the assistance of two staff for hygiene, toileting, and transfers. Continued review revealed the resident	F 323	**This POC is being submitted in compliance with federal regulations and SOM. It is not intended to be used as an admission or for any other purpose other than the purpose stated herein.** 1. On May 12, 2012 the care plan for resident #4 was updated to reflect that the resident requires assistance of two caregivers for transfers and incontinent care. Also on 5/12/2012 the resident's low bed was changed to a PVC low bed which is closer to the floor. On 5 / 8 / 12 a perimeter mattress was ordered to further prevent the risk of falling. The anticipated arrival date for the mattress is May 22, 2012. 2. All Residents with a high fall risk could be affected by this deficient practice. Fall risk assessments are done on each resident upon admission, quarterly and/or with significant changes and following a fall. All care plans will be audited and updated by May 31, 2012 to reflect the degree of assistance needed for incontinent care and transfers. This will be done by the director of nursing, assistant director of nursing, the resident care plan coordinator and the chart audit nurses.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert G Polselli	Administrator	5-18-2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 had a history of falls. Medical record review of a care plan effective through August 27, 2012, revealed, "At risk for falls...Give degree of assistance needed with transfers..." Review of facility investigation documentation dated April 17, 2012, revealed, "...Unwitnessed Fall/Found on Floor...CNA (certified nursing assistant) attempting to change resident to transfer to chair resident became combative - CNA stepped to door to get assistance - Resident rolled in bed and fell to floor, found resident in floor...2 abrasions R (right) knee with no bleeding. S/T (skin tear) R elbow 1 cm (centimeter) x 1 cm..." Observation on May 1, 2012, at 3:35 p.m., revealed the resident in a low bed with a pressure sensitive alarm pad, 1/4 siderails raised on both sides of the bed, and a mattress on the floor in front of the bed. Interview with CNA #1 on May 2, 2012, at 1:23 p.m., in a conference room, revealed the resident was able to move around while in bed prior to the fall on April 17, 2012, and CNA #1 stated, "... (Resident)tries to squirm about..." Interview with CNA #2 on May 2, 2012, at 1:23 p.m., in a conference room, revealed the resident had required assistance of two staff for transfers prior to the fall on April 17, 2012. Interview with the Assistant Director of Nursing on May 2, 2012, at 1:55 p.m., in a conference room, confirmed the facility failed to provide adequate	F 323	3. The staff member that left resident #4 unattended to get help was counseled on 5/17/12 by the director of nurses regarding the care for confused and combative residents. The staff member was instructed to stay with the resident during provision of care and to use the call light, yell for help, and/or put the pad back beside the mattress if the caregiver must leave. Staff education was provided on 5/2/12 by the Administrator and the ADON about the appropriate way to care for combative and confused residents with fall risk. 4. Chart and care plan audits will be performed by the audit nurses to monitor completion of fall risk assessments and that each care plan reflects the individualized degree of assistance required for the resident. The results of these findings will be reported by the Director of Nurses in the next quarterly PI/QA committee meeting which includes but not limited to: the medical director, the DON, the ADON, the Nursing Home Administrator, the Director of Rehab for the nursing home, the care plan coordinator, audit nurses and dietitian.	

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F 323	Continued From page 2 supervision and/or assistance to prevent a fall for Resident #4 on April 17, 2012.	F 323		